WellCare Health Plans

We're in this together: Quality Health Care

Behavioral Health Service Request Form

PHP and IOP Services as Covered

Please Submit to the Dedicated Contract Fax Line Below

Medicaid
Georgia – 888-871-0590

☐	**Standard Request**	Requests for prior authorization (with supporting clinical information and documentation) should be sent to the Health Plan seven (7) days prior to the date the requested services will be performed.
☐	**Expedited Request**	By signing below, I certify that applying the standard review time frame may seriously jeopardize the life or health of the member or the member's ability to regain maximum function. _____ Physician Signature Validating Expedited Request _____ Date Signed

Place of Service	☐ **11- Office** ☐ **22- Outpatient Hospital** ☐ **52- Psychiatric Facility-Partial Hospitalization** ☐ **53- Community Mental Health Center**
Treatment Focus	☐ **Mental Health** ☐ **Substance Use Disorder** ☐ **Dual Diagnosis**

MEMBER INFORMATION

Last Name		**First Name, Middle Initial**		**Date of Birth**	
Phone Number		**WellCare ID Number**		**Gender**	☐ **Male** ■ **Female**
Third Party Insurance	☐ **Yes** ☐ **No**	If **Yes**, please attach a copy of the insurance card. If the card is not available, provide the name of the insurer, policy type, and number.		**Languages Spoken**	

TREATING PROVIDER/PRACTITIONER INFORMATION

Last Name		**First Name**		**NPI Number**	
WellCare ID Number		**Participating**	☐**Yes** ☐ **No**	**Discipline/ Specialty**	
Street Address		**City, State**		**Zip**	
Phone Number		**Fax Number**		**Office Contact**	

FACILITY/AGENCY INFORMATION

Name		**Facility ID**		**NPI Number**	
Street Address		**City, State**		**Zip**	
Phone Number		**Fax Number**		**Office Contact**	

Service type Requested	REV/HCPCS Code(s) and Number of Days/Units Requested	
PHP	**REV/HCPC Code (s) :**	**Number of Days/Units :**
IOP	**REV/HCPC Code (s) :**	**Number of Days/Units :**

Service Request Start Date:	**Projected Length of Stay:**	**Transition of Care** ☐ **Yes** ☐ **No**	**Continuation of Care** ☐ **Yes** ☐ **No**

DIAGNOSIS – Code and Description

Primary Diagnosis	
Secondary Diagnosis	
Medical Diagnosis	

Are services requested court ordered? ☐ **Yes** ☐ **No** ***If yes please submit a copy of the court order and all supporting documentation***

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CLINICALS DETAILS			
Current Symptoms and Behaviors:			
Is there a trigger event identified? ☐ **Yes** ☐ **No** **Please describe :**			
Is member motivated for treatment?	☐ **Yes** ☐ **No**	**Is Transportation available?**	☐ **Yes** ☐ **No**

CURRENT RISKS		
Check the risk level for each category and check all boxes that apply.		
Risk to self (SI)	☐ **0** ☐ **1** ☐ **2** ☐ **3**	**With** ☐ **ideation** ☐ **intent** ☐ **plan** ☐ **means**
Risk to others (HI)	☐ **0** ☐ **1** ☐ **2** ☐ **3**	**With** ☐ **ideation** ☐ **intent** ☐ **plan** ☐ **means**
Current serious attempt or non-suicidal self injury	☐ **Yes** ☐ **No (if yes, describe below)**	**Check:** ☐ **SI** ☐ **HI**
If above checked yes, please describe :		
Date of most recent attempt or non-suicidal self injury:		
Prior serious attempt non-suicidal self injury	☐ **Yes** ☐ **No (if yes, describe below)**	**Check:** ☐ **SI** ☐ **HI**
If above checked yes, please describe :		

Substance Abuse/Co-Morbidity

Does the member have a current Substance Use Disorder? ☐ **Yes** ☐ **No**

Is the member currently intoxicated? : ☐ Yes ☐ No	If yes, please list substance (s) used :
Is the member currently experiencing withdrawal symptoms ? : ☐ Yes ☐ No	If yes, please list substance (s) used :

Please check off all withdrawal symptoms the member is experiencing :

☐	**Hand Tremors**	☐	**Impaired attention /memory**	☐	**Psychomotor agitation**
☐	**Sweating/Weakness**	☐	**Nausea/Vomiting**	☐	**Anxiety/Irritability**
☐	**Nystagmus**	☐	**Fluctuating vital signs**	☐	**Changes in Mood / Personality**
☐	**Insomnia**	**Vital Signs:**			
Has member been medically cleared? ☐ **Yes** ☐ **No**					

ADDITIONAL DATA TO SUPPORT REQUEST

Is a psychiatrist involved in the member's care? ☐ **Yes** ☐ **No**

If yes, when was the member last seen and what services are being rendered?

Is member currently receiving Outpatient services? ☐ **Yes** ☐ **No**

Any Previous Inpatient, Residential/Rehab, PHP, or IOP treatment? ☐ **Yes** ☐ **No**

Level of Care :	Name or Provider / Facility :	Dates:	Successful :
Inpatient :			☐ **Yes** ☐ **No**
Residential :			☐ **Yes** ☐ **No**
IOP / PHP :			☐ **Yes** ☐ **No**
Outpatient :			☐ **Yes** ☐ **No**
Intensive Community Based Treatment :			☐ **Yes** ☐ **No**

If treatment was not successful, please explain :

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Please explain why the member cannot be managed safely in a less intensive level of care :

SUPPORT SYSTEMS & PERFORMANCE

Relationship/Supports (identify issues/concerns: Is support available / Is support substance free?)
What are the environmental/community stressors and/or supports that contribute to the member's clinical status?
Role performance school/work issues/concerns:
Describe the member/family engagement in treatment:
Current living situation: ☐ homeless ☐ independent ☐ family ☐ foster home ☐ incarcerated ☐ other:
Is the member at risk of legal intervention or out-of-home placement? ☐ Yes ☐ No (describe)

CURRENT MEDICATIONS (Psychotropic and Medical)

Medication:	Dosage :	Frequency :	Compliant :
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
Are there any medication contraindications? If yes, please describe :			

Discharge Plan upon Admission :

ATTACHMENTS

☐ Current Treatment Plan	☐ Biopsychosocial Assessment	☐ Court Order	☐ Psychiatric Report	☐ Other:

CONTINUED STAY REVIEWS

For continued stay, provide a narrative of the current symptoms/behaviors that have occurred within the last week that support the need for partial hospitalization or intensive outpatient services. Summarize the progress or lack of progress and justification for continued stay. If there is no documented progress, explain how this is being addressed.
Continued symptoms/behaviors:
Scale: 0 = none; 1 = mild; 2 = moderate; 3 = severe; N/A = not assessed

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Check the impairment level for each category and provide a brief description

Symptom:	Scale:	Description:	Symptom:	Scale:	Description:
Functioning	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A		Ability to follow instructions	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A	
Complete assignments	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A		Perform ADLs	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A	
Cravings/preoccupation with substances	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A		Drug-seeking behaviors	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A	
Withdrawal symptoms	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A				

Types of services offered	Total number of sessions attended	Total number of sessions missed	Member Cooperative with Treatment?	Please provider an explanation of any "NO" responses
Individual Therapy			☐ Yes ☐ No	
Group Therapy			☐ Yes ☐ No	
Substance Abuse Counseling			☐ Yes ☐ No	
Family Therapy			☐ Yes ☐ No	
Psychiatric Interventions			☐ Yes ☐ No	

CURRENT MEDICATIONS (Psychotropic and Medical)

Medication:	Dosage :	Frequency :	Compliant :
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
Are there any medication contraindications? If yes, please describe :			

Detail any updates or changes to the discharge plan:

ATTACHMENTS

☐ Current Treatment Plan ☐ Biopsychosocial Assessment ☐ Court Order ☐ Psychiatric Report ☐ Other:

Georgia Families® Choices for a Healthy Life | PeachCare for Kids® | Planning for Healthy Babies®

WellCare proudly serves the *Georgia Medicaid* and *PeachCare for Kids®* members enrolled in the *Georgia Families®* program and women enrolled in the *Planning for Healthy Babies®* program.